

Veterans' Medical Care Appropriations and Funding Process

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Summary

The Department of Veterans Affairs (VA) provides benefits to veterans who meet certain eligibility rules. Benefits to veterans range from disability compensation and pensions to hospital and medical care. VA provides these benefits to veterans through three major operating units: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA). VHA is primarily a direct service provider of primary care, specialized care, and related medical and social support services to veterans through an integrated health care system. Veterans are enrolled in priority groups that determine payments for service and nonservice-connected medical conditions. In FY2004, Congress appropriated \$28.4 billion for VHA to be spent through an account structure composed of four new accounts: medical services, medical administration, medical facilities, and medical and prosthetic research.

For FY2005, the Administration submitted its budget request to Congress using a new account structure that consolidated several accounts into two “business lines”: medical care, and medical and prosthetic research. The Administration requested \$29.1 billion for VHA for FY2005.

On September 9, 2004, the House Committee on Appropriations reported the FY2005 appropriations bill for the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies for FY2005 (H.R. 5041) (H.Rept. 108-674). The Committee rejected the alternative appropriations structure recommended by the Administration and recommended \$30.3 billion for VA medical programs for FY2005. This is an increase of \$1.2 billion over the President’s request and \$1.9 billion over FY2004. On September 21, 2004, the Senate Committee on Appropriations reported its version of the FY2005 VA-HUD appropriations bill, S. 2825 (S.Rept. 108-353). Under S. 2825, as reported, VHA would have received \$30.4 billion in FY2005. This is a \$2 billion increase from FY2004, and \$1.2 billion more than the President’s request. On November 20, 2004, both the House and Senate adopted the conference agreement to accompany the Consolidated Appropriations Act, 2005 (H.R. 4818, P.L. 108-447). The bill was signed into law on December 8, 2004. Under P.L. 108-447, VHA would receive \$30.3 billion in FY2005 — an increase of \$1.2 billion over the FY2005 appropriation request, and \$1.9 billion over FY2004.

In its budget submission to Congress, the Administration also proposed several legislative and regulatory changes to increase certain copayments and other cost-sharing charges for lower-priority veterans and to reduce copays for certain veterans. The House and Senate Committees on Appropriations, and the final conference agreement did not accept any of the Administration’s cost-sharing proposals for VHA. This report will not be updated.

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Recent Developments

On September 9, 2004, the House Committee on Appropriations reported a bill making appropriations for the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies for FY2005 (VA-HUD appropriations bill) (H.R. 5041).¹ Under H.R. 5041, the Veterans Health Administration (VHA) would receive \$30.3 billion in FY2005. This is a \$1.9 billion increase from FY2004 and \$1.2 billion more than the President's request. It includes \$19.5 billion for medical services, \$4.7 billion for medical administration, \$3.7 billion for medical facilities, \$385 million for the medical and prosthetic research, and \$2 billion in medical care collections. Furthermore, the Committee recommended approximately \$370 million from the Construction Major account, and nearly \$162 million from the Construction Minor account for Capital Asset Realignment for Enhanced Services (CARES) activities. The Committee rejected the Administration's proposal to fund VHA through an alternative appropriations structure, in which the VHA budget would have been consolidated into two business lines: medical care, and medical and prosthetic research. It also disregarded the Administration's proposal to increase copayments and fees for lowest-priority veterans.

The Senate Committee on Appropriations reported its version of the VA-HUD appropriations bill for FY2005 (S. 2825) on September 21, 2004.² Under S. 2825 VHA would receive \$30.4 billion in FY2005. This is a \$2 billion increase from FY2004, and \$1.2 billion more than the President's request. It includes \$19.5 billion for medical services,³ \$4.7 billion for medical administration, \$3.7 billion for medical facilities, \$405 million for the medical and prosthetic research, and \$2 billion in medical care collections. The Committee also recommended \$370 million from the Construction Major account, and \$182 million from the Construction Minor account for CARES activities. The Committee also rejected the Administration's proposal

¹ U.S. Congress, House Committee on Appropriations, *Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Bill, 2005*, report to accompany H.R. 5041, 108th Cong., 2nd sess., H.Rept. 108-674.

² U.S. Congress, Senate Committee on Appropriations, *Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Bill, 2005*, report to accompany S. 2825, 108th Cong., 2nd sess., S.Rept. 108-353.

³ This amount includes \$1.2 billion designated as an emergency requirement. By being designated as an emergency requirement, the funding is not subject to enforcement procedures under the congressional budget process.

to fund VHA through an alternate account structure and did not include any copayment changes that were proposed in the budget.

On November 20, 2004, both the House and Senate adopted the conference agreement to accompany the Consolidated Appropriations Act, 2005 (H.R. 4818, P.L. 108-447).⁴ Under P.L. 108-447 VHA would receive \$30.3 billion in FY2005 an increase of \$1.2 billion over the FY2005 appropriation request, and \$1.9 billion over FY2004. None of the funds would be contingent upon an emergency declaration as proposed by the Senate Appropriations Committee (S. 2825). P.L. 108-447 provides \$19.5 billion to finance medical services. Furthermore, it appropriates \$4.7 billion for medical administration, \$3.7 billion for medical facilities, and \$405 million for medical and prosthetic research. Funding for VHA includes \$2 billion in medical care collections (MCCF). The conference agreement also includes \$370 million from the Construction Major account, and \$182 million from the Construction Minor account for CARES related activities. It should be noted that these amounts are not included in the total VHA budget since Construction Major and Construction Minor accounts are funded through separate construction accounts. The conferees of the Consolidated Appropriations Act, 2005 rejected the Administration's proposal to fund VHA through an alternative account structure, and did not include any copayment changes that were proposed in the President's budget request.

This report will first provide a brief summary of the FY2004 budget for VHA care along with a general discussion of the budget process in order to provide a context for this summary. Second, the report will provide information on the President's FY2005 budget request for VHA.⁵ Third, it will discuss the Administration's major legislative and regulatory proposals for VA medical care for FY2005. This report has been updated to show the amounts recommended by the House and Senate, and enacted by Congress and signed into law by the President.

Veterans Health Administration (VHA)

The Department of Veterans Affairs (VA) provides benefits to veterans who meet certain eligibility rules. Benefits to veterans range from disability compensation and pensions, education, training and rehabilitation services, hospital and medical care, and other benefits such as home loan guarantees and death benefits (including burial expenses). VA provides these benefits to veterans through three major operating units: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA). VA's budget includes both mandatory and discretionary spending accounts. *Mandatory funding* supports disability compensation, pension benefits, vocational rehabilitation, and life insurance, among other benefits and services. *Discretionary funding*

⁴ U.S. Congress, Conference Committees, *Consolidated Appropriations Act, 2005*, conference report to accompany H.R. 4818, 108th Cong., 2nd sess., H. Rept 108-792. The Consolidated Appropriations Act, 2005 was signed into law on December 8, 2004.

⁵ The terms "Administration's budget," "President's budget," "Administration's budget request" and "President's budget request" refer to the same document. These terms are used interchangeably throughout this report.

supports a broad array of benefits and services, including medical care. In FY2004, discretionary budget authority accounted for approximately 47% of the total VA budget authority, with most of this discretionary funding going toward supporting VA medical care.

VHA operates the largest direct health care delivery system in the nation.⁶ In FY2003, VHA operated 160 hospitals, 134 nursing homes, 42 residential rehabilitation treatment centers, and 847 ambulatory care and community-based outpatient clinics. VHA also pays for care provided to veterans by independent providers and practitioners on a fee basis under certain circumstances. In addition, VHA provides grants for construction of state-owned nursing homes and domiciliary facilities, and collaborates with the Department of Defense (DOD) in sharing health care resources and services.

During FY2003, VHA provided medical services to an estimated 4.5 million unique veteran patients, a caseload that is expected to reach approximately 4.7 million in FY2004 and approximately 4.9 million by the end of FY2005.⁷ The total number of outpatient visits reached 49.7 million during FY2003, and is projected to increase to 53.1 million in FY2004 to 56.4 million in FY2005. In FY2003, VHA spent approximately 50% of its medical care obligations on outpatient care.

In addition, VHA manages the largest medical education and health professions training program in the United States. Veterans' health care facilities are affiliated with 107 medical schools, 55 dental schools and more than 1,200 other schools across the country. Each year, about 81,000 health professionals are trained in VA medical centers.

VA Health Care Enrollment

To understand VA's medical care appropriations and the Administration's major policy proposals discussed later in this report, it is important to understand VA's enrollment process and its enrollment priority groups. The Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262) required the establishment of a national enrollment system to manage the delivery of inpatient and outpatient medical care. The new eligibility standard was instituted by Congress to "ensure that medical judgment rather than legal criteria will determine when care will be provided and the level at which care will be furnished."⁸

⁶ Established in 1946 as the Department of Medicine and Surgery, succeeded in 1989 by the Veterans Health Services and Research Administration, renamed the Veterans Health Administration (VHA) in 1991.

⁷ This number and projections exclude Readjustment Counseling, State Home, Civilian Health and Medical Program of VA (CHAMPVA), Spina Bifida, the Foreign Medical Program, and non-veterans. Data provided by VA.

⁸ H.Rept. 104-690.

For most veterans, entry into the veterans' health care system begins with application for enrollment.⁹ A veteran may apply for enrollment at any time during the year. Eligibility for VA health care is primarily based on "veteran status" resulting from military service. "Veteran status" is established by active-duty status in the military, naval, or air service and a honorable discharge or release from active military service.

After "veteran status" has been established, VA next places applicants into one of two categories. The first is composed of the following veterans:

- veterans in need of care for a service-connected disability¹⁰;
- veterans who have a compensable service-connected condition;
- veterans whose discharge or release from active military, naval, or air service was for a compensable disability that was incurred or aggravated in the line of duty;
- veterans who are former POWs;
- veterans awarded the Purple Heart;
- veterans who have been determined by VA to be catastrophically disabled;
- veterans of World War I;
- veterans seeking care for disorders associated with exposure to hazardous agents (such as Agent Orange in Vietnam) while on active duty; and
- veterans who have annual income and net worth below a VA-established means-test threshold.

In general, the above-mentioned veterans are regarded as "high priority" veterans, and they are enrolled automatically in one of the first six priority groups. (A detailed list of priority enrollment groups is provided in **Appendix 1**.) VA also looks at applicants' income and net worth to determine their specific priority category and whether they have to pay copayments for nonservice-connected care. In addition, veterans are asked to provide VA with information of any health insurance coverage they have — including coverage through employment or through a spouse. These payers will be the primary payer for nonservice-connected conditions only.

The second group is composed of veterans who do not fall into one of the first six categories above. These veterans are primarily those with nonservice-connected

⁹ Veterans do not need to apply for enrollment in VA's health care system if they fall into one of the following categories: veterans with a service-connected disability rated 50% or more (percentage ratings represent the average impairment in earning capacity resulting from diseases and injuries encountered as a result of or incident to military service; those with a rating of 50% or more are placed in Priority Group 1); less than one year has passed since the veteran was discharged from military service for a disability that the military determined was incurred or aggravated in the line of duty, but the VA has not yet rated; or the veteran is seeking care from VA for only a service-connected disability (even if the rating is only 10%).

¹⁰ The term "service-connected" means, with respect to disability, that such disability was incurred or aggravated in the line of duty in the active military, naval, or air service.

conditions and with incomes and net worth above the VA-established means test threshold. In general, these veterans are enrolled in Priority Group 7 or 8, and must agree to pay copayments for the care they receive for nonservice-connected conditions. (**Table 1** provides information on what categories of veterans pay for which services.)

Table 1. Veterans' Payments for Health Care Services

	Copayments			Insurance Billing
	Inpatient	Outpatient	Medication ^a	
Priority Group 1	No	No	No	Yes, but only if care was for nonservice-connected condition
Priority Groups 2, 3, ^b 4 ^c	No	No	Yes, but only for veterans with less than 50% service connected disability and medication is for nonservice-connected condition	Yes, but only if care was for nonservice-connected condition
Priority Group 5	No	No	Yes	Yes, but only if care was for nonservice-connected condition
Priority Group 6 (WWI, and 0% service-connected compensable)	No	No	Yes	Yes, but only if care was for nonservice-connected condition
Priority Group 6 (Veterans receiving care for exposure or experience) ^d	No ^d	No ^d	No ^d	Yes, but only if care was for nonservice-connected condition
Priority Group 7 ^e	Yes	Yes	Yes	Yes, but only if care was for nonservice-connected condition
Priority Group 8 ^f	Yes	Yes	Yes	Yes, but only if care was for nonservice-connected condition

Source: *President's Task Force to Improve Health Care Delivery for Our Nation's Veterans*

Note: All veterans receiving prescriptions for nonservice-connected conditions who meet the low-income criteria (established by the means test), and veterans who are former POWs are exempt from medication copayments.

- An annual medication copayment cap has been established for veterans enrolled in Priority Groups 2-6. Medication will continue to be dispensed after copayment cap is met. An annual copayment cap has not been established for Priority Groups 7 or 8 veterans.
- Veterans in receipt of a Purple Heart are in Priority Group 3. This change occurred with the enactment of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) on November 30, 1999.
- Priority Group 7 veterans who are determined to be catastrophically disabled and who are placed in Priority Group 4 for treatment are still subject to the copayment requirements as a Priority Group 7 veteran.
- Priority Group 6 — health insurance and all applicable copayments will be billed when care is for conditions not related to the veteran's experience or exposure. Veterans in this priority group could be subject to full medical care copayments or reduced inpatient copayments under means-

- test criteria for nonservice-connected conditions. Combat veterans receiving care for a potential service-related condition within two years of discharge from the military are in Priority Group 6.
- e. Priority Group 7 veterans — For inpatient copayments only, veterans in this priority group are responsible for 20% of the inpatient copayment (in traditional insurance this is known as a deductible) and 20% of the inpatient per diem copayment. The means-tested copayment reduction does not apply to outpatient and medication copayments and veterans will be assessed the full applicable copayment charges for nonservice-connected care.
 - f. Priority Group 8 veterans — For inpatient copayments only, veterans in this priority group are responsible for the full inpatient copayment (in traditional insurance this is known as a deductible) and the inpatient per-diem copayment. Veterans in this priority group are also responsible for the full outpatient and medication copayments for nonservice-connected care. There is no means-tested copayment reduction.

Funding for VHA

VHA is funded through multiple appropriations accounts that are supplemented by other sources of revenue. Although the appropriations account structure has been subject to change from year to year, traditionally the appropriation accounts used to support VHA include medical care, medical and prosthetic research, and medical administration. In addition, Congress also appropriates funds for construction of medical facilities through a larger appropriations account for construction applicable to all VA facilities. Furthermore, the Committees on Appropriations include medical care cost-recovery collections when considering the amount of resources needed to provide funding for VHA. VHA is authorized to bill some veterans and most health care insurers for nonservice-connected care provided to veterans enrolled in the VA health care system, to help defray the cost of delivering medical services to veterans. The Balanced Budget Act of 1997 (P.L.105-33) gave VHA the authority to retain these funds in the Medical Care Collections Fund (MCCF). Instead of returning these funds to the Treasury, VA can use this for medical services for veterans without fiscal year limitations.

FY2004 VHA Budget Highlights

In general, the federal budget process begins with the submission of the President's budget request to Congress. Following this submission, the Budget Committees of the House and Senate develop the annual budget resolution which sets forth aggregate spending and revenue levels, by functional levels of spending, for the upcoming fiscal year and at least the following four fiscal years.¹¹ The budget resolution is not binding and does not allocate funds among specific programs or accounts, but the major program assumptions underlying the functional amounts are often discussed in the accompanying report.¹² The House and Senate Appropriations Committees subdivide their allocations among their respective 13 subcommittees, each of which is responsible for one of the regular appropriations acts. Authorizing committees for certain programs may also consider legislation that will affect spending under their programs. A committee has the discretion to decide on the legislative changes to be recommended. It is not bound by the program changes

¹¹ Specifically, budget function 700 includes funding for VA benefits and services.

¹² For more information on the formulation of the budget resolution, see CRS Report 98-512 GOV, *Formulation and Content of the Budget Resolution*, by Bill Heniff, Jr.

recommended or assumed by the Budget Committees in the reports accompanying the budget resolution.¹³ Enumerated below are major highlights of the congressional budget process, beginning with the President's request to enact spending levels for VA medical care for FY2004.

The Administration requested approximately \$27.5 billion for VHA for FY2004; this included approximately \$1.8 billion in medical care collections (see **Table 2**). The House Veterans Affairs, Housing and Urban Development, and Independent Agencies FY2004 appropriations bill (FY2004 VA-HUD appropriations bill) recommended a new account structure for VHA.¹⁴ The FY2004 VA-HUD appropriations bill proposed establishing four new accounts: medical services, medical administration,¹⁵ medical facilities,¹⁶ and medical and prosthetic research. The FY2004 VA-HUD appropriations bill included approximately \$16.4 billion for medical services, which included nearly \$1.5 billion from the Medical Care Collections Fund (MCCF) (the bill language did not provide the \$1.5 billion as a separate line item, and it is not shown under the MCCF line on **Table 2**). In addition, the FY2004 VA-HUD appropriations bill included approximately \$4.9 billion for medical administration, \$4 billion for medical facilities, and \$408 million for medical and prosthetic research. In total, the House FY2004 VA-HUD appropriations bill provided VHA approximately \$25.7 billion.

The Senate's appropriations bill (S. 1584) did not propose modifying the FY2003 account structure¹⁷ and the Senate approved approximately \$25.7 billion for medical care. In addition, S. 1584 provided approximately \$413 million for medical and prosthetic research, and provided approximately \$80 million for medical administration and miscellaneous operating expenses. In total, the Senate bill provided VHA approximately \$28.6 billion for FY2004, including approximately \$1.6 billion from MCCF.

¹³ The VA, HUD, and Independent Agencies appropriations bill is one of 13 regular appropriations bills that Congress passes each year. For details on funding for other VA programs, see CRS Report RL31804, *Appropriations for FY2004: VA, HUD and Independent Agencies*, by E. Richard Bourdon and Paul Graney.

¹⁴ H.R. 2861

¹⁵ The medical administration account provides for expenses related to the headquarters offices of the Veterans Health Administration as well as the costs of Veterans Integrated Service Network (VISN) offices and facility directors, expenses associated with information technology hardware and software, legal services, billing and coding activities, procurement, and related activities, among other expenses.

¹⁶ The medical facilities account provides funds for the operation, maintenance, and security of VA medical facilities and also includes amounts for the cost associated with utilities, laundry and food services, garbage disposal, facility repair among other things, but does not include funds for construction of facilities. Spending for these purposes is included in the medical care account in both the Administration's and Senate's proposals.

¹⁷ In FY2003 VHA was funded through the following four accounts: medical care; medical and prosthetic research; medical administration and miscellaneous operating expenses; and MCCF.

The Consolidated Appropriation Act, 2004 (P.L. 108-199)¹⁸ provided funding for VHA based on the account structure proposed in H.R. 2861. The new accounts that are funded are medical services, medical administration, medical facilities, and medical prosthetic research. According to the Conference Committee, this account structure will provide for “better oversight and a more accurate accounting of funds.” P.L. 108-199 provided approximately \$17.9 billion for medical services, \$5 billion for medical administration, \$4 billion for medical facilities, and \$408 million for medical and prosthetic research. In total, P.L. 108-199 provided \$28.6 billion for the Veterans Health Administration, including a separate amount for MCCF.

The following table shows appropriations to VA medical care programs for FY2003, and for FY2004, the Administration's request (based on the Conference Committee's account structure), the amounts recommended by the House and the Senate, and the amounts ultimately approved by Congress and signed into law by the President.

Table 2. VHA Appropriations FY2003-FY2004
(\$ in thousands)

Program	FY2003 enacted	FY2004 request	FY2004 House	FY2004 Senate	FY2004 Conference
Medical services	—	—	16,443,220	—	17,867,220
Medical administration	—	—	4,854,000	—	5,000,000
Medical facilities	—	—	4,000,000	—	4,000,000
Medical and prosthetic research	397,400	408,000	408,000	413,000	408,000
Medical care	23,889,304	25,218,000	—	25,688,080 ^a	—
delayed obligations ^b	—	—	—	1,100,000	—
rescission ^c	—	—	—	-270,000	-270,000
Medical administration and miscellaneous operating expenses (old)	74,230	79,140	—	79,146	—
Medical care cost collection (MCCF) ^d	1,386,000	1,800,000	—	1,564,000	1,564,000
Total: VHA (appropriations for programs and administration)	\$25,746,934	\$27,505,220	\$25,705,220	\$28,574,226	\$28,569,220

Source: H.Rept. 108-401.

Note: Totals may not add due to rounding. FY2004 amounts do not include effects of the 0.59% across-the-board rescission in most discretionary accounts, as called for in P.L. 108-199.

a. This amount includes \$1.3 billion in emergency funding for medical care.

¹⁸ H.R. 2673

- b. The Senate Committee on Appropriations included bill language delaying availability of \$1.1 billion for medical care to provide flexibility to VA to implement significant program changes.
- c. The Senate Committee on Appropriations included bill language that canceled budget authority of \$270 million, representing prior years recoveries for medical care.
- d. Medical Care Collections Fund (MCCF) receipts are restored to the VHA as an indefinite budget authority equal to the revenue collected, estimated to be \$1.386 billion in FY2003. The amount initially projected for FY2004 was \$1.8 billion; the conferees on the VA-HUD portion of the Consolidated Appropriations Act (P.L. 108-199) used a later estimate of \$1.564 billion.

FY2005 VHA Budget

Changes in the VA Medical Care Account Structure

The Administration proposed a new account structure for VHA for FY2005, consolidating several accounts under a medical care business line, and two accounts under a medical research business line. A brief description of the accounts consolidated into the two business lines is provided in **Appendix 2**.

On July 22, 2004, the House Committee on Appropriations approved by voice vote the FY2005 VA-HUD appropriations bill (H.R. 5041). This bill was reported out of committee on September 9, 2004 (H.Rept.108-674). As reported, H.R. 5041 recommended \$30.3 billion for VA medical programs for FY2005. This is an increase of \$1.2 billion over the President's request and \$1.9 billion over FY2004. The Committee did not adopt the Administration's alternative appropriations structure and provided funding using the FY2004 account structure. According to the committee report, this was because the Administration's proposed account structure "does not address the needs of Congress in its role of reviewing and allocating federal budgetary resources."¹⁹ Furthermore, the Committee asserts that the FY2004 account structure provides better oversight and a more accurate accounting of funds.

The Senate Committee on Appropriations reported its version of the FY2005 VA-HUD appropriations bill (S. 2825) (S.Rept. 108-353) on September 21, 2004. The Committee also did not adopt the Administration's account structure and provided funding using the FY2004 account structure. In its report, the Committee advised the Administration "to be sensitive to the administrative burden on VA staff in implementing major account changes, and to take this concern into mind when exploring future account changes."²⁰

As reported, S. 2825 recommended \$30.4 billion for VA medical programs for FY2005. This is an increase of \$1.2 billion over the President's request and \$2 billion over FY2004. Of the total amount appropriated for medical programs, the

¹⁹ U.S. Congress, House Committee on Appropriations, *Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Bill, 2005*, report to accompany H.R. 5041, 108th Cong., 2nd sess., H.Rept. 108-674.

²⁰ U.S. Congress, Senate Committee on Appropriations, *Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Bill, 2005*, report to accompany S. 2825, 108th Cong., 2nd sess., S.Rept. 108-353.

Committee designated \$1.2 billion as an emergency requirement.²¹ According to the committee report, this was due to “unanticipated and urgent need of veterans seeking medical treatment and services.”²²

On November 20, 2004, both the House and Senate adopted the conference agreement to accompany the Consolidated Appropriations Act, 2005 (H.R. 4818, P.L. 108-447).²³ The bill was signed into law by the President on December 8, 2004. Under P.L. 108-447, VHA would receive \$30.3 billion in FY2005 — an increase of \$1.2 billion over the FY2005 appropriation request and \$1.9 billion over FY2004. None of the funds would be contingent upon an emergency declaration as proposed by the Senate Appropriations Committee (S. 2825). The conferees rejected the Administration’s proposal to fund VHA through an alternative account structure. According to the conference report, the conferees continue to believe the current account structure started in FY2004, composed of four accounts — medical services, medical administration, medical facilities, and medical and prosthetic research — “will provide better oversight and achieve a more accurate accounting of funds.”²⁴

Table 3 presents the President’s FY2005 budget request as well as the amounts recommended by the House Committee on Appropriations, the Senate Committee on Appropriations, and the committee of conference for FY2005. Note that the medical care total in the President’s budget request includes spending for medical services, medical administration, and construction of facilities.

²¹ By being designated as an emergency requirement, this funding is not subject to enforcement procedures under the congressional budget process.

²² U.S. Congress, Senate Committee on Appropriations, *Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Bill, 2005*, report to accompany S. 2825, 108th Cong., 2nd sess., S.Rept. 108-353.

²³ U.S. Congress, Conference Committee, *Consolidated Appropriations Act, 2005*, conference report to accompany H.R. 4818, 108th Cong., 2nd sess., H. Rept 108-792.

²⁴ U.S. Congress, Conference Committee, *Consolidated Appropriations Act, 2005*, conference report to accompany H.R. 4818, 108th Cong., 2nd sess., H. Rept 108-792.

Table 3. VHA FY2004 Appropriation, FY2005 Budget Request, and Amounts Recommended
(\$ in thousands)

Program	FY2004 appropriation	FY2005 request	FY2005 House Approp. Committee	FY2005 Senate Approp. Committee	FY2005 Conference
Medical services	\$17,762,054	—	\$19,498,600	\$19,498,600 ^a	\$19,472,777
Medical administration	4,970,500	—	4,705,000	4,705,000	4,705,000
Medical facilities	3,976,400	—	3,745,000	3,745,000	3,745,000
Medical and prosthetic research	405,593	\$384,770	384,770	405,593	405,593
Medical care	—	26,748,600	—	—	—
rescission	-270,000	—	—	—	—
Medical care cost collection (MCCF)	1,554,772	2,002,000	2,002,000	2,002,000	2,002,000
Total: VHA (appropriations for programs and administration)	\$28,399,319	\$29,135,370	\$30,335,370	\$30,356,193	\$30,330,370

Source: H.Rept. 108-674; S.Rept.108-353; H.Rept. 108-792

a. This amount includes \$1.2 billion designated as an emergency requirement.

Note: Appropriation amounts for FY2004 adjusted to account for the 0.59% across-the board reduction in most discretionary accounts, as called for in P.L.108-199. Includes rescission of \$270 million in unobligated balances remaining from prior year recoveries and reappropriated to Medical Care in FY2004. FY2005 budget estimates are not adjusted to account for the 0.8% across-the-board rescission in most discretionary accounts as called for in P.L.108-447.

Capital Asset Realignment for Enhanced Services (CARES) Program-Related Construction

Much of VA's physical infrastructure was built decades ago when the agency's focus was providing inpatient care. VA has been shifting from a hospital-based system providing inpatient care to one that emphasizes outpatient care in outpatient hospital settings and community-based clinics. Today, more than 80% of the services that VA provides to veterans are on an outpatient basis. VA's CARES initiative is an attempt to create a strategic framework to upgrade the health care-delivery capital infrastructure and ensure that scarce resources are placed in the types of facilities and locations that would best serve the needs of the veteran population. In August 2003, VA released the Draft National CARES Plan. Following the release of the draft plan, the VA Secretary appointed a 16-member independent commission to evaluate the draft plan. The CARES Commission submitted its recommendations to the Secretary in February 2004. After reviewing the recommendations, the Secretary announced the final details of the CARES plan in May 2004. The plan proposes new hospitals in Orlando, FL, and Las Vegas, NV, 156 new community-based outpatient clinics, four new spinal cord injury centers, two rehabilitation centers for the blind, and expanded mental health outpatient services nationwide. In some cases, the plan also

calls for transferring care from antiquated facilities to more modern or better-situated VA facilities or contracting for care in local communities. By opening health care access to more veterans, VA expects to increase the percentage of enrolled veterans from 28% of the veteran population today, to 30% in 2012 and 33% in 2022.

The Secretary's final decision on the CARES Commissions Report deferred action on nine facilities, pending completion of feasibility and/or cost-benefit studies.²⁵ Further study was directed to facilitate more specific conclusions about the regional health care requirements associated with each facility.

VA has developed a seven-year funding model to estimate the additional capital required to implement the CARES program. The model was based on the preliminary data from the Veterans Integrated Services Network (VISN) 12 CARES study. To assess capital requirements at a macro level, CARES used projections of beds and outpatient primary care, mental health, and specialty care. VA plans to revise the funding model as additional CARES data are available. It should be noted that any CARES-related major construction project would still need to receive a specific appropriation from Congress.

In the Administration's budget request for FY2005, a portion of the funds from the Construction Major and Construction Minor accounts that are part of the medical care account in **Table 3** (see **Appendix 2**) would be used to begin implementing recommendations stemming from studies associated with the Capital Asset Realignment for Enhanced Services (CARES) program.

The House Committee on Appropriations recommended approximately \$371 million from the Construction Major account, and nearly \$162 million from the Construction Minor account for CARES program activities. In its report, the House Appropriations Committee expressed concern about "the limited consultation by VA with local communities during some aspects of the CARES programs." In addition, the Committee "directs VA to defer final action on any facility undergoing a feasibility study, as directed by the Secretary's final decision on the CARES Commission Report, until affected stakeholders have been given adequate opportunity to consult with the feasibility study task forces and VA on the future of these facilities."²⁶

The Senate Committee on Appropriations recommended approximately \$371 million from the Construction Major account, and \$182 million from the Construction Minor account for CARES program activities. In its report, the Committee strongly urges VA to establish an independent body to advise and monitor the progress of CARES in order to ensure that the implementation of the

²⁵ The nine facilities are located in the following areas: Boston, MA; New York City; Big Spring, TX; Montgomery, AL; Louisville, KY; Muskogee/Tulsa, OK; Poplar Bluff, MO; Waco, TX; Walla Walla, WA.

²⁶ U.S. Congress, House Committee on Appropriations, *Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Bill, 2005* report to accompany H.R. 5041, 108th Cong., 2nd sess., H.Rept. 108-674.

CARES program is “objective and not vulnerable to subjective changes.”²⁷ The Committee also urged VA to develop a plan for disposing of its vast inventory of vacant and unneeded infrastructure.

The Consolidated Appropriations Act, 2005 (P.L.108-447) provides \$370 million from the Construction Major account, and \$182 million from the Construction Minor account for CARES-related activities. The accompanying conference report agrees with language in the Senate report (S.Rept. 108-353) urging the Secretary of Veterans Affairs to establish an independent CARES advisory body.

Note that the Construction Major and Construction Minor accounts are funded through separate construction accounts, and not through the VA health care budget. These accounts do not appear on **Table 3**.

Changes in the Cost-Sharing Structure

In its FY2005 budget request, the Administration proposed several regulatory and legislative changes to VA's cost-sharing structure. According to the VA, these changes would have allowed the agency to refocus the VA health care system to better serve the highest-priority core veterans. These veterans are those with service-connected conditions, those with lower incomes and those with special health care needs. Among the most significant legislative and regulatory proposals in the budget are:

- Increasing veterans' share of pharmaceutical copayments from \$7 to \$15 (for each 30-day prescription) for all enrolled veterans in Priority Groups 7 and 8;
- Increasing veterans' share of copayments for outpatient primary care from \$15 to \$20 (for each medical appointment) for all enrolled veterans in Priority Groups 7 and 8;
- Establishing an annual user fee of \$250 for all enrolled veterans in Priority Groups 7 and 8;
- Ending pharmacy copayments for veterans in Priority Groups 2 through 5 with incomes between \$9,894 and \$16,509; this would allow approximately 394,000 veterans to receive outpatient medications without having to make a copayment;²⁸
- Ending long-term care copayments for former prisoners of war;
- Authorizing the department to pay for emergency room care or urgent care for enrolled veterans in non-VA medical facilities;
- Ending hospice copayments.

A brief description of each of the above proposals follows.

²⁷ U.S. Congress, Senate Committee on Appropriations, *Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Bill, 2005*, report to accompany S. 2825, 108th Cong., 2nd sess., S.Rept. 108-353.

²⁸ Testimony of VA Secretary Anthony Principi in U.S. Congress, House Committee on the Budget, *Hearing on FY2005 Budget for the Department of Veterans Affairs*, prepared statement, 108th Congress 2nd sess., Feb. 12, 2004.

Increase Veterans' Share of Pharmacy Copayments. The Administration proposed to increase the pharmacy copayments from \$7 to \$15 for all enrolled Priority Group 7 and Priority Group 8 veterans whenever they obtain medication from VA on an outpatient basis for the treatment of a nonservice-connected disability. At present, veterans in Priority Groups 2-8 pay \$7 for a 30-day supply of medication, including over-the-counter medications.²⁹

The Veterans Millennium Health Care and Benefits Act of 1999 (P. L. 106-117) authorized VA to increase the medication copayment amount and to establish annual caps on the medication copayment amount.³⁰ An annual cap was established to eliminate financial hardship for veterans enrolled in Priority Groups 2-6. When veterans reach the annual cap, they will continue to receive medications without making a copayment. For calendar year 2004, the cap is \$840. There is currently no cap for veterans in Priority Groups 7 and 8. According to the VA's actuarial projections, the increase in prescription drug copayments would have resulted in a reduction of \$83 million in prescription drug costs and generated an additional \$135 million in copayment revenue, allowing Congress to reduce the VA appropriation by \$218 million.

Increase Veterans' Share of Copayments for Outpatient Primary Care. The President's budget proposed increasing the primary care copayment amount from \$15 to \$20 for a basic outpatient visit. This would have applied to all enrolled Priority Group 7 and 8 veterans.

The current copayment rates of \$15 for a primary care visit and \$50 for nonservice-connected specialty care visit went into effect on December 6, 2001.³¹ The new regulation implemented a three-tier copayment system for outpatient care. Services such as preventive screening and immunizations are free. Primary care visits, which include diagnosis and management of acute and chronic conditions, and the large majority of personal health care needs, cost \$15. Specialty care, such as ambulatory surgery, MRIs, audiology, optometry, and care by specialists, which can be provided only through a referral from a primary care provider, costs \$50. According to VA's actuarial projections, the increase in the primary care copayment would have resulted in a reduction of \$8 million in health care costs and would have generated an additional \$7 million in copayment revenue, allowing Congress to reduce the VA appropriation by \$15 million. Furthermore, VA asserted that the increase in the primary care copayment from \$15 to \$20 would have had a minimal impact on utilization of VA health care.

²⁹ Veterans receiving a pension from VA for a nonservice-connected disability, veterans with incomes below \$9,894 (if single), and \$12,959 (if married), veterans receiving care for conditions such as Agent Orange, combat veterans within two years of discharge, and veterans who are former POWs are exempt from paying copayments.

³⁰ This law allowed VA to increase the copayment amount for each 30-day or less supply of medication provided on an outpatient basis (other than medication administered during treatment) for treatment of a nonservice-connected condition.

³¹ Department of Veterans Affairs, "Copayments for Inpatient Hospital Care and Outpatient Medical Care," 66 *Federal Register* 235, Dec. 6, 2001.

The Veterans Millennium Health Care and Benefits Act of 1999 (P.L. 106-117), gave VA the authority to change copayment amounts. Therefore VA does not need congressional approval to increase the primary care copayment amount from \$15 to \$20 for an outpatient visit.

Assess an Annual User Fee of \$250. The Administration proposed to assess an annual user fee of \$250 for all enrolled Priority Group 7 and 8 veterans. According to the VA Secretary, the user fee would have been assessed only when a veteran sought care. VA believes that veterans with higher incomes rely less on VA for health care and have other health care options; therefore, it believes the fee will not have an impact on many veterans.

In its FY2004 budget submission, the Administration requested authority from Congress to levy an annual “enrollment fee” on nonservice-connected Priority Group 7 and all Priority Group 8 veterans. However, Congress did not approve imposing such a fee. In its FY2005 budget submission, the Administration has once again proposed charging all Priority Group 7 and 8 veterans an “annual enrollment” fee. However, in subsequent testimony before Congress, Secretary Principi described this as an annual “user fee” that will be collected only when a veteran seeks medical services.

According to the actuarial projections done by VA, the \$250 initial user fee was expected to reduce the number of Priority Group 7 and 8 patients in FY2005 by approximately 211,000. The initial user fee would have resulted in a reduction of \$141 million in health care costs and would have generated an additional \$268 million in copayment revenue, allowing Congress to reduce the VA appropriation by \$409 million.

Pharmacy Copayment Relief for Some Veterans. The Administration proposed to eliminate the pharmacy copayment burden for nonservice-connected conditions of Priority Group 2-Priority Group 5 veterans by raising the income threshold from \$9,894 (if single) to \$16,509 (if single). VA maintained that by using this rate it will be able to further focus its resources on its core constituency — that is, low-income veterans with service-related conditions.

Ending Copayments for Former Prisoners of War (POWs). The Veterans Health Care, Capital Asset, and Business Improvement Act of 2003 (P.L. 108-170) required VA to exempt former POWs from medication copayments for treatment of both service-connected and nonservice-connected conditions. With the passage of this legislation, former POWs do not have to pay copayments for hospital and medical services (including copayments for medications). This applies to treatment of both service-connected and nonservice-connected conditions. However, former POWs do have to pay copayments for long-term care services. The Administration asked Congress to exempt former POWs from copayment obligations for long-term care services as well. This would have effectively ended any remaining copayments obligations among former POWs for VA health care.

Emergency Care for Insured Veterans. Under current law, VA is authorized to reimburse all veterans for emergency treatment furnished in non-VA facilities for nonservice-connected conditions if they meet the following criteria: (1)

they have enrolled in VA's health care system; (2) they have received care from VA within the 24-month-period preceding the provision of such emergency treatment; and (3) they are financially liable to the provider for the emergency treatment. Veterans who have health insurance coverage for emergency care, or are entitled to other federal benefits care (i.e., under Medicare or Medicaid), or have other contractual or legal recourse are not eligible for reimbursement.³² However, VA does not reimburse out-of-pocket expenses associated with such care.³³

In its FY2005 budget request, the Administration proposed that VA would pay insured veterans' out-of-pocket expenses for emergency care services if emergency care is obtained outside the VA health care system. VA would have been a secondary payer to private insurance or Medicare for emergency care services. VA would have paid for the out-of-pocket expenses, less the amount of the copayment the veteran would have been required to pay if the veteran had received care from VA.

Copayment Exemption for Hospice Care. Under current law, veterans receiving hospice care for a terminal illness may be subject to copayment obligations depending upon the type of VA facility in which they receive care. Hospice care received in a nursing home is exempt from extended-care copayments. Those veterans who seek hospice care at a hospital (not in a nursing home) are subject to an inpatient copayment. If veterans receive hospice care at home, they are subject to outpatient copayments for their hospice care. The Administration proposed that hospice care provided in all settings should be exempt from all inpatient and outpatient copayments.

The FY2005 VA-HUD appropriations bills reported by the House and Senate Committees on Appropriations and the final conference agreement to accompany the Consolidated Appropriations Act, 2005, did not include any of the copayment changes that had been proposed in the President's budget request.

Continue to Suspend Enrollment

On January 17, 2003, the Secretary of Veterans Affairs announced that VA would temporarily suspend enrolling Priority Group 8 veterans. This was included as a policy proposal in the Administration's FY2004 budget request. The FY2005 budget request continued this policy of suspending enrollment of new Priority Group 8 veterans.

According to this policy proposal, those who enrolled in the VA health care system before January 17, 2003 would not be affected by this suspension. VA justified suspending enrollment of Priority Group 8 veterans by asserting that even with budgetary increases, the agency will be unable to provide all enrolled veterans with timely access to health care services because of the tremendous growth in the number of veterans seeking VA health care.

³² Veterans Millennium Health Care and Benefits Act (P.L. 106-117).

³³ VA fully reimburses veterans for emergency treatment obtained in non-VA medical facilities for service-connected disabilities (38 U.S.C. § 1728)

In January 2003, VA estimated that there were almost 236,000 enrolled veterans who have been unable to schedule an appointment within less than six months of the desired date.³⁴ At present, VA is reporting that this number has been reduced to approximately 36,000.³⁵ VA contends that resources should be focused on VA's core population — those veterans with service-connected disabilities, with lower incomes, and special needs such as the blind and those with spinal cord injuries. Although the Administration included this proposal in the budget request, VA does not need congressional approval to implement it. The Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262) gives the Secretary the authority to suspend enrollment when there are insufficient resources to provide quality health care.

Suspending enrollment of Priority Group 8 veterans affected approximately 164,000 veterans for FY2003. If this suspension continues, it would affect an estimated 360,000 veterans by the end of FY2004, and 522,000 veterans by the end of FY2005. According to VA, it will continue to enroll veterans in Priority Groups 1 through 7, adding approximately 380,000 veterans during FY2003 into these categories.

A veteran who is not enrolled will still be eligible for hospital and outpatient care for certain conditions, including the following: (1) conditions related to military sexual trauma, (2) head or neck cancer related to nose or throat radium treatment while in the military, (3) readjustment counseling services, (4) treatment related to service-connected conditions. Moreover, recently discharged veterans who have served in combat theaters such as Afghanistan and Iraq can receive health care for conditions potentially related to their services for up to two years.

³⁴ Department of Veterans Affairs, "Enrollment — Provision of Hospital and Outpatient Care to Veterans Subpriorities of Priority Categories 7 and 8 and Annual Enrollment Level Decision," 68 *Federal Register* 2670, Jan. 17, 2003.

³⁵ U.S. Congress, Committee on Veterans Affairs, Report to the Committee on the Budget on the Budget Proposed for Fiscal Year 2005, Committee Print, 108th Cong., 2nd sess., Mar. 4, 2004, p. 1.

Appendix 1. Priority Groups and Their Eligibility Criteria

Priority Group 1 Veterans with service-connected disabilities rated 50% or more disabling
Priority Group 2 Veterans with service-connected disabilities rated 30% or 40% disabling
Priority Group 3 Veterans who are former POWs Veterans awarded the Purple Heart Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty Veterans with service-connected disabilities rated 10% or 20% disabling Veterans awarded special eligibility classification under 38 U.S. C. § 1151, “benefits for individuals disabled by treatment or vocational rehabilitation”
Priority Group 4 Veterans who are receiving aid and attendance or housebound benefits Veterans who have been determined by VA to be catastrophically disabled
Priority Group 5 Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds Veterans receiving VA pension benefits Veterans eligible for Medicaid benefits
Priority Group 6 Compensable 0% service-connected veterans World War I veterans Mexican Border War veterans Veterans solely seeking care for disorders associated with <ul style="list-style-type: none"> — exposure to herbicides while serving in Vietnam; or — ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or — for disorders associated with service in the Gulf War; or — for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.
Priority Group 7 Veterans who agree to pay specified copayments with income and/or net worth <i>above</i> the VA Means Test threshold and income <i>below</i> the HUD geographic index Subpriority a: Noncompensable 0% service-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date Subpriority c: Nonservice-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date. Subpriority e: Noncompensable 0% service-connected veterans not included in Subpriority a above Subpriority g: Nonservice-connected veterans not included in Subpriority c above
Priority Group 8 Veterans who agree to pay specified copayments with income and/or net worth <i>above</i> the VA Means Test threshold and the HUD geographic index Subpriority a: Noncompensable 0% service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date Subpriority e: Noncompensable 0% service-connected veterans applying for enrollment after January 16, 2003

Source: Department of Veterans Affairs

Note: Service-connected disability means with respect to disability, that such disability was incurred or aggravated in the line of duty in the active military, naval or air service

Appendix 2. Medical Care Business Line and the Medical Research Business Line Accounts in the Administration's FY2005 VHA Budget

Medical Care Business Line

Medical Care. The medical care appropriation would provide for medical care and treatment of eligible veterans, and certain dependents and survivors of veterans. In addition, this appropriation would also provide for training of medical residents and interns and other professional paramedical and administrative personnel in the health care field.

Medical Care Collections Fund (MCCF). VA deposits copayments collected from veterans obligated to make such payments for either medical services or inpatient pharmacy benefits for outpatient medication,³⁶ and third-party insurance payments from service-connected veterans for nonservice-connected conditions into the MCCF.³⁷ However, copayments, third-party insurance payments, and fees for services other than medical services or inpatient pharmacy benefits were deposited in several medical collections accounts.

In FY2004, the Administration's budget proposed consolidating several medical collections accounts into the MCCF. The conferees of the Consolidated Appropriations Act [H.Rept. 108-401]³⁸ recommended that collections which would otherwise be deposited in the entities formerly known as the Health Services Improvement Fund, the Veterans Extended Care Revolving Fund, the Special Therapeutic and Rehabilitation Activities Fund, the Medical Facilities Revolving Fund, and the Parking Revolving Fund be deposited in the MCCF. The funds deposited in the MCCF would be available for medical services for veterans. These collected funds do not have to be spent in any particular fiscal year and are available until expended. The following describes former collection accounts now consolidated under the MCCF, and current programs.

Pharmacy Copayments (formerly collected in the Health Services Improvement Fund — HSIF). In FY2002, Congress created a new fund (the Health Services Improvement Fund) to collect increases in pharmacy copayments (from \$2 to \$7 for a 30-day supply of outpatient medication) that went into effect on February 4, 2002. The Consolidated Appropriations Resolution, 2003 (P.L. 108-7)

³⁶ P.L. 105-33, the Balanced Budget Act of 1997, extended the authority to recover copayments for outpatient medication until Sept. 30, 2002. P.L. 108-7, the Consolidated Appropriation Resolution 2003, granted permanent authority to recover copayments for outpatient medication.

³⁷ P.L. 107-135, the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, extended the authority to recover third-party insurance payments from service-connected veterans for nonservice-connected conditions through Oct. 1, 2007.

³⁸ Enacted as the Consolidated Appropriations Act, 2004 (P.L. 108-199).

granted VA the authority to consolidate the HSIF with the MCCF and granted permanent authority to recover copayments for outpatient medications.

*Long-Term Care Copayments (formerly Veterans Extended Care Revolving Fund).*³⁹ This fund received per diems and copayments from certain veteran patients receiving extended care services from VA providers or outside contractors. According to the Administration's budget documents, extended care services are defined as geriatric evaluation, nursing home care, domiciliary services, respite care, adult day health care, and other noninstitutional alternatives to nursing home care.⁴⁰

*Compensated Work Therapy Program (formerly the Special Therapeutic and Rehabilitation Activities Fund).*⁴¹ The Compensated Work Therapy (CWT) program is a comprehensive rehabilitation program that prepares veterans for competitive employment and independent living. The major goals of the program are: (1) to use remunerative work to maximize a veteran's level of functioning; (2) to prepare veterans for successful reentry into the community as productive citizens, and; (3) to provide a structured daily activity to those veterans with severe and chronic disabling physical and/or mental conditions. As part of their work therapy, veterans produce items for sale or undertake subcontracts to provide certain products and/or services (such as providing temporary staffing to a private firm). Funds collected from the sale of these products and/or services were used to fund the program.

*Compensation and Pension Living Expenses Program (formerly the Medical Facilities Revolving Fund).*⁴² Under this program, veterans who do not have either a spouse or child would have their monthly pension reduced to \$90 after the third month he or she is admitted for nursing home care. The difference between the veteran's pension and the \$90 was used for the operation of the VA medical facility.

Parking Program (formerly the Parking Revolving Fund). The program provided funds for construction and acquisition of parking garages at VA medical facilities. VA collects fees for use of these parking facilities.

National Program Administration (Formerly Medical Administration and Miscellaneous Operating Expenses, MAMOE). The National Program Administration provides support to VA's comprehensive and integrated health care system by headquarters staff. Specific activities include the development and implementation of policies, plans, and broad program activities; assistance for the

³⁹ Authority to collect long-term care copayments was established by the Millennium Health Care and Benefits Act (P.L. 106-117).

⁴⁰ Department of Veterans Affairs, *FY2005 Budget Submissions, Medical Programs*, (vol. 2 of 4), pp. 2A-32.

⁴¹ The program was created by the Veterans' Omnibus Health Care Act of 1976 (P.L. 94-581).

⁴² The program was established by the Veterans' Benefits Act of 1992 (P.L. 102-568).

networks in attaining their objectives and necessary follow-up action to ensure complete accomplishment of goals including the capital facilities management and development functions.

Construction Major. Funds from this account would be for construction, altering, extending and improving any of the facilities used by VA. Any project that costs more than \$7 million falls under this category.

Construction Minor. Funds from this account would be used for construction, altering, extending and improving any of the facilities used by VA. Any project that costs \$500,000 or more, and less than \$7 million falls under this category.

Grants for Construction of Extended-Care Facilities. Under this program grants are provided to states to acquire or construct state owned and/or funded nursing home and domiciliary facilities, and to remodel, modify, or alter existing buildings for furnishing domiciliary or nursing home care for veterans in state nursing homes. The Veterans Health Care Act of 1992 (P.L. 102-585) granted permanent authority for this program. The Millennium Health Care and Benefits Act (P.L. 106-117) reformed the construction grant program by giving higher priority to critically needed renovations, such as projects involving fire- and life-safety improvements in existing state homes. Prior to the enactment of this law, such projects were given lower priority than grants for constructing new state nursing homes.

VA/ DOD Health Care Sharing Incentive Fund. The National Defense Authorization Act for FY2003 (P.L. 107-314) directed the Secretaries of Defense and Veterans Affairs to enter into agreements and contracts for the mutually beneficial coordination, use, or exchange of use of health care resources with the goal of improving access to, and the quality and cost-effectiveness of, the health care provided to beneficiaries. Under this act, VA and the Department of Defense must establish a joint incentive fund, with each Department contributing a minimum of \$15 million to the fund. At present, the two Departments are in the process of establishing the fund and developing criteria for its use. The program is set to expire in 2007.⁴³

Medical Research Business Line

Medical and Prosthetic Research. In addition to providing medical care, VA conducts medical, rehabilitative, and health services research. The medical and prosthetic research program is an intramural program. Funds from this appropriation are allocated to support VA employees conducting research projects. In addition to funds from this appropriation, reimbursements from DOD, grants from the National Institutes of Health, and private sources support VA researchers. Medical research supports both basic and advanced clinical studies.

⁴³ For further information see U.S. General Accounting Office, *VA Incentives Program for Sharing Health Resources*, GAO-04-495R DOD, Feb. 2004.

The prosthetic research program is involved in the development of prosthetic, orthopedic, and sensory aides to improve the lives of disabled veterans. The health services research program focuses on improving the outcome effectiveness and cost efficiency of health care delivery for veterans.

Medical Care Research Support. Prior to the proposed new account structure, funds appropriated under the medical care account were used for the indirect cost of VA research. These indirect costs include costs of heating, lighting, and other utilities associated with laboratory space, administrative costs associated with human resources needed for research, and supply services attributed to research.

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